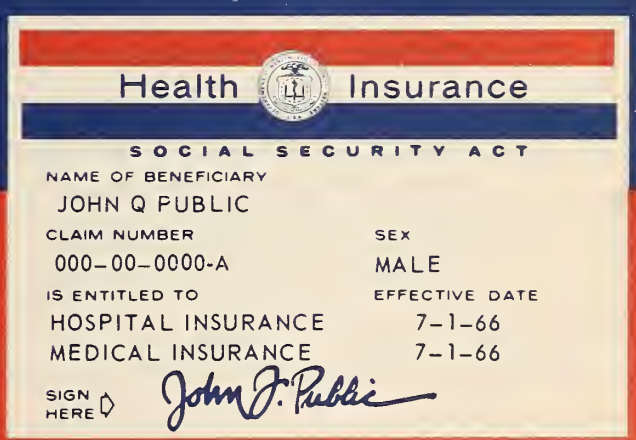
INCLUDING 1967 CHANGES

Your Medicare Handbook



HEALTH INSURANCE UNDER SOCIAL SECURITY

SSI-50
MAY 1968

HOSPITAL INSURANCE (PART A)
MEDICAL INSURANCE (PART B)

#1

Dear Beneficiary:

This is Your Medicare Handbook. It explains the benefits you are entitled to under Medicare and tells how the program works.

This handbook includes the many important changes in your hospital insurance and medical insurance protection made by the 1967 social security amendments. An index on the back cover lists these changes, and this symbol '67 shows where they are explained on the page.

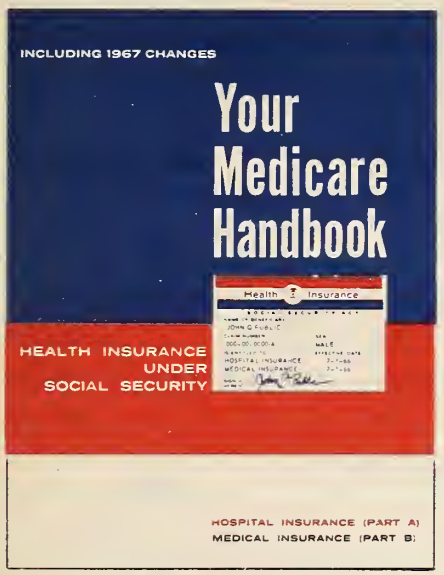
You may also want to pay particular attention to the new term "benefit period" which we have decided to use now instead of the words "spell of illness." This change is described on page 6.

I believe the handbook will answer most of your questions about Medicare, but some details have necessarily been omitted. If you need further information or want help concerning your Medicare protection or any other social security matters, please get in touch with your social security office. The people there are always glad to help you.

Sincerely yours,

Robert M. Ball

ROBERT M. BALL
Commissioner of Social Security



Like Medicare, your handbook has two parts. . .

PART A

- The *first* section describes *hospital insurance*, often called *Part A* of Medicare. This is the part that helps pay for your care when you are in the hospital and for related health services, when you need them, after you leave the hospital.

PART B

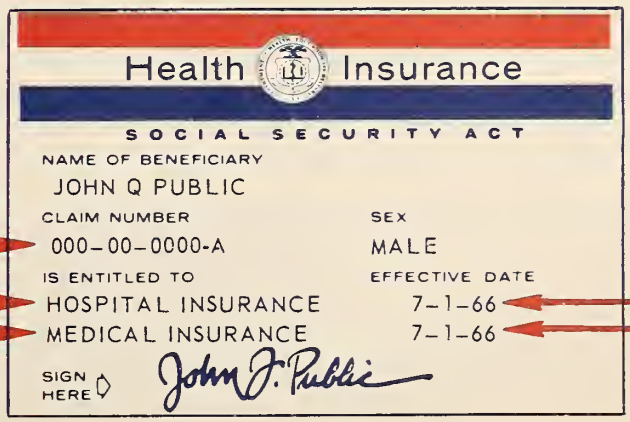
- The *second* section describes *medical insurance*, often called *Part B* of Medicare. This is the part that helps pay your doctor bills and bills for other medical services you need.

Your Medicare health insurance card shows the protection you have

The people at the hospital, doctor's office, or wherever you get services, can tell from your health insurance card that you have both hospital and medical insurance and when each started. This is why you should always have your card with you when you receive services.

When a husband and wife both have Medicare, they receive separate cards and claim numbers.

If you ever lose your health insurance card, the people in your social security office will get you a new one.



This is your personal health insurance claim number. It must be shown on all Medicare claims exactly as it is shown on your card—INCLUDING THE LETTER AT THE END.

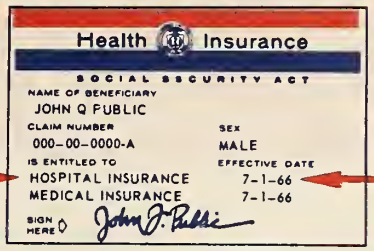
This shows you have hospital insurance.

This shows you have medical insurance.

The dates your insurance starts are shown here.

Table of Contents

This shows that you are entitled to the benefits described in the hospital insurance part of this handbook.


Health Insurance
SOCIAL SECURITY ACT
NAME OF BENEFICIARY
JOHN Q PUBLIC
CLAIM NUMBER
000-00-0000-A
SEX
MALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL INSURANCE 7-1-66
MEDICAL INSURANCE 7-1-66
SIGN HERE ◊ John J. Public

The date your hospital insurance starts is shown here.

HOW HOSPITAL INSURANCE WORKS

Your hospital insurance helps pay for the services you receive from health facilities participating in Medicare when you are:

- **A BED PATIENT IN A HOSPITAL,**

And . . . if you need further care *after* a hospital stay, when you are

- **A BED PATIENT IN AN EXTENDED CARE FACILITY,** or
- **A PATIENT AT HOME RECEIVING SERVICES FROM A HOME HEALTH AGENCY.**

The services hospital insurance helps pay for are called *covered services.* These are described on the following pages. Your hospital insurance *covers almost all of the services* you would ordinarily receive as a bed patient in a participating hospital or extended care facility or as a patient at home receiving services from a participating home health agency. Your hospital insurance will also, in some cases, help pay for care in certain hospitals that do not participate in Medicare (see page 12).

When you receive covered services from a participating hospital, extended care facility, or home health agency, you do not need to make any claim for your hospital insurance benefits. These institutions or agencies make the claims and receive the Medicare payment. They have agreed to charge you only for services which are not covered by Medicare.

You will always receive a notice from the Social Security Administration when a payment has been made on your behalf.

Health Facilities Must Meet Certain Conditions to Take Part in Medicare

To participate in the Medicare program, health facilities must meet standards which help assure that they will be able to provide high quality health care. In addition, they must not charge the Medicare beneficiary for services paid for by the program, and they must abide by title VI of the Civil Rights Act, which prohibits discrimination based on race, color, or national origin.

How Often You Can Use Your Hospital Insurance Benefits—and How Your Benefits Can Be Renewed

Your use of hospital insurance benefits is limited to certain *maximum* amounts for certain periods of time—but there is a way for your hospital insurance benefits to *start over again* (except the "lifetime reserve" described on page 8). You can figure out yourself how this works:

HOW THE USE OF HOSPITAL INSURANCE BENEFITS IS COUNTED

WHEN YOU ARE—	YOUR PART A BENEFITS ARE—
• A bed patient in a hospital.	• Up to 90 "hospital days" for *each* "benefit period."
• A bed patient in an extended care facility.	• Up to 100 "extended care days" for *each* "benefit period."
• A patient at home receiving home health services.	• Up to 100 "home health visits" for *each* "benefit period." (Page 11 describes the 1-year time limit on these visits.)

These three kinds of benefits and how you qualify for them are described in more detail on the following pages. But, as you can see, you can get up to these total numbers of "days" and "visits" for *each* "benefit period." So you need to know what a "benefit period" is to know how often you can use your hospital insurance benefits.

WHAT IS A "BENEFIT PERIOD"?

A "benefit period" is simply a period of time for measuring your use of hospital insurance benefits. (In the first Medicare Handbook and in some other Medicare publications, we called this period of time a "spell of illness," which is the term used in the law. But because many people thought this term had something to do with a single illness or a particular "spell" of sickness, we are now calling it a "benefit period.") This is how it works.

The first time you enter a hospital after your hospital insurance starts will be the beginning of your *first* benefit period. Your first benefit period *ends* as soon as you have not been a bed patient in any hospital (or any facility that mainly provides skilled nursing care) for *60 days in a row*. After that, a *new* benefit period begins the next time you enter a hospital—and *that* benefit period ends as soon as you have *another* 60 days in a row when you are not a bed patient in any hospital (or any facility that mainly provides skilled nursing care). Then *another* benefit period can begin the *next* time you enter a hospital—and so on.

There is no limit to the number of benefit periods you may have. There is an easy way to remember the rule. Just keep in mind that *any time* you are not in any hospital or other facility mainly providing skilled nursing care for *60* days in a row a *new* benefit period will begin the next time you go into a hospital. And, of course, for each new benefit period, your full hospital insurance benefits are available again to use as you need them.

You Get a Personal Record of Benefits Used

You don't have to bother about trying to keep track of how many "days" or "visits" you use in each benefit period. The notice you receive from the Social Security Administration after you have used any hospital insurance benefits will tell you how many benefit "days" and "visits" you have left in that benefit period. But, very few people who enter a hospital or extended care facility, or use home health services, need these services long enough to use all the benefits they have for a benefit period. So most people will never run out of "days" or "visits," because a new benefit period will almost always start with full benefits available again the next time they are needed.

EXAMPLE:

Mr. L was in the hospital for 2 weeks and then went home.

After Mr. L has been at home for 75 days, he returns to the hospital. When Mr. L is admitted this time, he is in a new benefit period. That means he is again eligible for up to 90 hospital days because more than 60 days have gone by since he was last in a hospital or other facility that mainly provides skilled nursing care. The benefit days Mr. L used the time before do not matter because he is in a new benefit period.

How Hospital Insurance Benefits Are Financed

The hospital insurance program is financed by special contributions from employees and self-employed persons, with employers paying an equal amount. These contributions are collected along with regular social security contributions from the wages and self-employment income earned during a person's working years.

67 Until 1972, the contribution rate for the hospital insurance program is six-tenths of one percent of the first $7,800 of earnings. It will increase gradually until 1987 when it will reach the final rate of nine-tenths of one percent.

These contributions are put into the Hospital Insurance Trust Fund from which the program's benefits and administrative expenses are paid. Funds from general tax revenues are used to finance hospital insurance benefits for people who are covered under the program but are not entitled to monthly social security or railroad retirement benefits.

In addition, the law provides that the various dollar amounts for which the patient is responsible be reviewed annually. These dollar amounts include the first $40 of hospital charges in each benefit period and different per-day amounts after certain periods of benefit use in hospitals and extended care facilities. These are described on the following pages. The law also provides that if this annual review shows that hospital costs have changed significantly these amounts must be adjusted for the following year. However, no change in these amounts may be made before 1969.

NOTE: In April 1968, preliminary estimates indicated that increases in hospital costs would require an increase in the $40 deductible in 1969 (probably to $44) and small changes in the different per-day amounts required after certain lengths of stay in hospitals and extended care facilities. If such a change is required, it will be announced before October 1, 1968.

What Hospital Insurance Can Pay When You Are a Hospital Bed Patient

In each benefit period, your hospital insurance can help pay for *up to 90 days* of bed patient care in any participating general care, tuberculosis, or psychiatric hospital.

- For the first 60 days—hospital insurance pays for all covered services, *except for the first $40.*
- For the 61st through the 90th day—hospital insurance pays for all covered services, *except for $10 a day.*

IMPORTANT!

Once you have taken care of the ***first*** *$40* of hospital expenses in each benefit period, ***you do not have to pay it again,*** even if you have to go back in a hospital more than once in that same benefit period.

Also, You Have a "Lifetime Reserve" of 60 Additional Hospital Days

'67 This is like a "bank account" of extra days to draw from if you need them. You can use them if you ever need more than 90 days of hospital care in the same benefit period. For each "lifetime reserve" day used, hospital insurance pays for all covered services, except for $20 a day.

Each lifetime reserve day you use permanently reduces the total you have left.

Usually you will want to use your lifetime reserve days if you need hospital care after you have used all your 90 days in a benefit period. *Unless* you decide *not* to use them, the extra days of hospital care that you use are automatically taken from your lifetime reserve.

If for any reason you do not wish to use your reserve days, the hospital will ask you to say so in writing. In making your decision, you should consider any private insurance you have which may pay for some or all of your additional hospital care. And, of course, you may wish to talk to your doctor or the people at the hospital about whether in your particular situation you should draw on your lifetime reserve.

EXAMPLE: Mrs. S had to go to the hospital a number of times in the same benefit period and used up all her 90 days. Before a new benefit period could start she again needed to go to a hospital. She can draw from her "lifetime reserve" days to help her pay for the hospital care.

Special Rules for Benefits in Psychiatric Hospitals

For care in a psychiatric hospital, there is a lifetime limit of 190 hospital benefit days. Also, for a beneficiary who is a patient in a psychiatric hospital on the day his hospital insurance starts, there is a special limitation, which is described in Question 6 on page 13.

Your Benefits When You Are a Bed Patient in a Participating Hospital

The list below describes the kinds of benefits that hospital insurance will help pay for when you are a bed patient in a hospital and some of the services that it cannot pay for.

Part A Helps Pay For:

- Bed in a semiprivate room (2-4 beds in a room) and all meals, including special diets.
- Operating room charges.
- Regular nursing services (including intensive care nursing).
- Drugs furnished by the hospital.
- Laboratory tests.
- X-ray and other radiology services.
- Medical supplies such as splints and casts.
- Use of appliances and equipment furnished by the hospital such as wheelchairs, crutches, braces, etc.
- Medical social services.

Part A Does NOT Pay For:

- Personal comfort or convenience items (such as charges for telephone, radio, or television furnished at your request).
- Private duty nurses.
- Any extra charge for use of a private room, unless you need it for medical reasons.
- Doctors' services (your medical insurance helps pay for these).
- Custodial care.

An Example of How Hospital Insurance Helps Pay for Hospital Care

Mrs. C was in the hospital for 14 days.

During her stay in the hospital, Mrs. C had an operation. Her bill included the hospital charges for semiprivate room and all meals, including special diet; use of the operating room; X-rays, laboratory tests; oxygen; and drugs furnished by the hospital. There was also a charge of $9.25 for television and telephone services.

Of the total hospital bill of $798.25 Mrs. C paid $49.25. (This was the first $40 for that benefit period plus the charges for the television and telephone.) Her hospital insurance took care of the remaining $749. (And, of course, Mrs. C's medical insurance helped pay her doctor bills.)

Extended Care Benefits After You Leave the Hospital

Sometimes a patient no longer needs the intensive care which hospitals provide, but still needs full-time skilled nursing care and other health services which cannot be furnished in his home. In these cases, the doctor may transfer the patient from the hospital to an extended care facility. This is a specially qualified facility which is staffed and equipped to furnish full-time skilled nursing care and many important related health services.

Hospital insurance pays for all covered services in a participating extended care facility for the first 20 days you receive such services in each benefit period and all but $5 a day for up to 80 more days in that same benefit period if all the following are true:

1. A doctor determines that you need extended care and orders such care;
2. You have been in a participating (or otherwise qualified) hospital for at least 3 days in a row before your admission;
3. You are admitted within 14 days after you leave the hospital;
4. You are admitted for further treatment of a condition for which you were treated in the hospital.
5. The care is not custodial care.

If you leave an extended care facility and are readmitted to one within 14 days, you can continue to use your additional extended care benefit days for that benefit period, without a new 3-day stay in a hospital.

The following list describes some of the kinds of extended care services hospital insurance will help pay for and some of the services that it cannot pay for.

Part A Helps Pay For:	Bed in a semiprivate room (2-4 beds in a room) and all meals, including special diets.
	Regular nursing services.
	Drugs furnished by the extended care facility.
	Physical, occupational, and speech therapy.
	Medical supplies such as splints and casts.
	Use of appliances and equipment furnished by the facility such as wheelchairs, crutches, braces, etc.
	Medical social services.
Part A Does NOT Pay For:	Personal comfort or convenience items (such as charges for telephone, radio, or television furnished at your request).
	Private duty nurses.
	Any extra charge for use of a private room, unless you need it for medical reasons.
	Doctors' services (your medical insurance helps pay for these).
	Custodial care.

Custodial Care Is Not Covered

Sometimes the kind of care people receive is needed primarily to help them meet the needs of daily living, such as assistance in bathing, dressing, eating, walking, or taking medicine on a regular schedule. When meeting these needs is the *primary purpose* of the care being furnished, it is called custodial care.

Important as custodial care can be to many people, the law permits Medicare to pay for care only when its primary purpose is to meet the medical needs of the patient and when the patient requires health services which can only be provided by trained and skilled professional health personnel.

Home Health Benefits After You Leave the Hospital

After you have been in a hospital (or in an extended care facility *after* a hospital stay), your doctor may decide that the continued care you need can best be given in your own home through a home health agency. These agencies can send skilled people to your home to provide health care services such as part-time nursing; physical, occupational, and speech therapy; and part-time services of home health aides.

Hospital insurance pays for all covered services—for as many as 100 home health visits—furnished by a participating home health agency **for up to a year after your most recent discharge from a hospital or a participating extended care facility if all the following are true:**

1. You were in a participating (or otherwise qualified) hospital for at least 3 days in a row;
2. You are confined to your home;
3. A doctor determines that you need home health care and sets up a home health plan for you within 14 days after your discharge from the hospital or a participating extended care facility;
4. The home health care is for further treatment of a condition for which you received services as a bed patient in the hospital or extended care facility.

For an explanation of how "visits" are counted, see Question 9 on page 13.

The following list describes the kinds of home health services that hospital insurance will help pay for and some of the services that it cannot pay for.

Part A Helps Pay For:	Part-time nursing care.
	Physical, occupational, or speech therapy.
	Part-time services of home health aides.
	Medical social services.
	Medical supplies furnished by the agency.
	Use of medical appliances.
Part A Does NOT Pay For:	Full-time nursing care.
	Drugs and biologicals.
	Personal comfort or convenience items.
	Custodial care.
	Meals delivered to your home.

Benefits for Bed Patient Care in Hospitals That Do Not Take Part in Medicare

'67 **Nearly all hospitals in the country participate in Medicare.** But, if you are a patient in a hospital that does not take part in Medicare, your hospital insurance may be able to pay some of your bills.

IF YOU ARE ADMITTED TO A NON-PARTICIPATING HOSPITAL AFTER 1967 FOR EMERGENCY CARE

Your hospital insurance can help pay for emergency care in a non-participating hospital if the hospital meets certain conditions in the law, and if it is the closest or quickest hospital to get to that has a bed available and is equipped to handle the emergency.

If you receive emergency care in such a hospital, the benefit payment will usually be made to the hospital. However, the hospital may decide to bill you rather than Medicare; and in that case, the benefit payment may be made to you. For help in making your claim, call, write, or visit your social security office.

BENEFITS MAY BE PAYABLE FOR CERTAIN HOSPITAL ADMISSIONS BEFORE 1968

If for any reason you were admitted to a hospital *before* January 1, 1968, but could not get benefits because the hospital did not take part in Medicare, get in touch with your social security office before January 1, 1969. Benefits may now be payable.

Questions and Answers About Hospital Insurance

1. ***Where can I find out if a hospital, extended care facility, or home health agency is participating in Medicare?***

   Your doctor, or someone at the institution or agency, can tell you. Or you can ask the people in any social security office.

2. ***If I am injured while at work and my medical expenses are (or could be) covered by the workmen's compensation law, will my hospital insurance also pay?***

   No.

3. ***If I am well enough to go home from the hospital before I have used up the 90 days, will my hospital insurance continue to pay for my care if I want to stay in the hospital?***

   No. Hospital insurance only pays for services that are medically necessary.

   The law requires participating hospitals to have a utilization review committee made up of physicians and other professional people. This committee reviews hospital stays at various times and, in some cases, after consultation with your doctor, may find that there is no further need for hospital care.

   These provisions are not intended to deprive anyone of needed care, but rather to encourage the most effective use of hospital facilities by keeping down unnecessary hospital care.

4. ***Does hospital insurance pay for services in a foreign hospital?***

Questions and Answers About Hospital Insurance (continued)

No, but there is one exception: if (1) you are in the United States when an emergency arises and (2) the foreign hospital is closer than the nearest hospital in the United States which could provide the emergency care you need. Then hospital insurance will help pay for the emergency care.

5. ***Can hospital insurance pay anything toward the cost of my care in a Christain Science sanatorium?***

Yes. Your hospital insurance can cover certain hospital and extended care services furnished to inpatients of a sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, in Boston. For more information, ask at any social security office.

67 6. ***Is there a special rule for beneficiaries who are in a psychiatric hospital when their hospital insurance protection starts?***

Yes. When a person is a patient in a psychiatric hospital *at the time* his hospital insurance starts, the days in the mental hospital during the 150-day period just before his hospital insurance starts count against the total number of benefit days he can use in a psychiatric hospital in his first benefit period.

These days, however, do not count against his lifetime maximum of 190 days of payment for care as a patient in a psychiatric hospital. Nor do they count against his benefit days in his first benefit period if he goes to a *general hospital* for treatment of a condition other than mental illness. (For more information, get in touch with your social security office.)

7. ***What can I do if I think a mistake has been made in the amount of my hospital insurance benefits?***

The first thing to do is to ask someone at the hospital, extended care facility, or home health agency that provided the services. Usually they can answer your questions. Sometimes, however, they may need to refer you to the organization that handles their Medicare payments. If you are still not satisfied, get in touch with your social security office for information about your right to formal appeal.

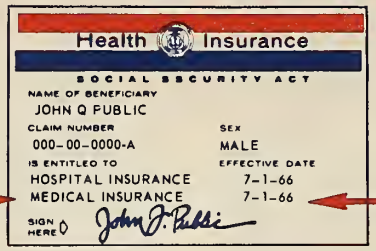
8. ***What if I cannot pay the amounts that hospital insurance does not pay?***

You may want to ask at your local public assistance office about help under a State program such as old-age assistance or medical assistance (sometimes called "medicaid").

9. ***What is a home health "visit"?***

One "visit" is counted *each* time you receive a covered health care service from a home health agency. If you receive two *different* services on the same day (for example, both a nurse and a physical therapist call on you), that would be *two* "visits." It would also be two "visits" if you received the *same* service twice in a day (such as two calls by a nurse).

This shows that you are entitled to all the benefits described in the medical insurance part of this handbook.



The date your medical insurance starts is shown here.

YOU PAY HALF THE COST OF YOUR MEDICAL INSURANCE PROTECTION

'67 The basic medical insurance premium for each person is $4 a month for the period from April 1, 1968, to July 1, 1969. Those who delayed signing up for a long period after their first chance or who signed up again after canceling it in the past are required by law to pay an additional 10 percent for each full year they were eligible but not enrolled. The premium is now $4.40 a month for those who did not enroll for a year or longer after they were eligible.

Your premium covers half the cost of your medical insurance protection. The Federal Government pays the other half for you.

The medical insurance premium rate must be reviewed annually. If necessary, the rate is changed to make sure that the total amounts collected in premiums and the equal amounts provided by the Government will continue to meet the full costs of the program. The results of the annual review are announced in December of each year. The change in the premium, if any, is effective for the 12-month period beginning the following July.

Medical insurance premiums are automatically deducted from monthly checks for those who receive social security benefits, railroad retirement benefits, or a civil service annuity. Those who do not receive any of these monthly checks pay their premiums directly to the Social Security Administration (or, in some cases, have premiums paid on their behalf under a State assistance program).

If You Ever Decide to Cancel

'67 You can cancel your medical insurance at any time. Your protection and your premiums will stop at the end of the calendar quarter after the quarter your notice is received. (A calendar quarter is any of the 3-month periods beginning with January 1, April 1, July 1, or October 1.)

If you do cancel your medical insurance, you have only one chance to get it back. You may sign up again in one of the "general enrollment" periods which begin within 3 years after you cancel your medical insurance. There is a general enrollment period *every* year—from January 1 through March 31. '67

If you should ever think of canceling your medical insurance protection, remember that you may not be able to get equal protection from other sources. Many Blue Cross-Blue Shield plans and commercial insurance companies do not offer broad coverage policies for people 65 and over, but only *extra* insurance for those who already have medical insurance under Medicare.

HOW MEDICAL INSURANCE WORKS

Your medical insurance helps pay for—

DOCTORS' SERVICES
OUTPATIENT HOSPITAL SERVICES
MEDICAL SERVICES AND SUPPLIES
HOME HEALTH SERVICES
OUTPATIENT PHYSICAL THERAPY
—and other health care services.

To understand the way medical insurance works, it will help to know the following terms.

Covered services: These are the kinds of services medical insurance can help pay for. (The reasonable charges for covered services also count toward the $50 deductible.)

$50 deductible: For each calendar year, medical insurance does not pay any of the first $50 of reasonable charges for covered services.

Reasonable charges: A charge is reasonable when it is the charge your doctor usually makes for the service you receive and is not more than the prevailing charge by doctors in your area for the same kind of service.

After your bills for covered services go over $50 for a calendar year, medical insurance will pay 80 percent of the reasonable charges for covered services for the rest of that year. (There are two exceptions to this rule. One is the special rule on page 17 and the other is described in Question 2 on page 30.)

Important: There is only *one* $50 medical insurance deductible each year—not a separate $50 deductible for each kind of covered service. Also, medical expenses in the last 3 months of one year can sometimes count toward the $50 deductible for the next year. This "carry-over" rule is described on page 24.

EXPLANATION OF BENEFITS NOTICE

Whenever a medical insurance claim is sent in, you will receive a statement showing your use of medical insurance benefits. This statement will show you how much of your expenses have been credited to your $50 deductible and the amount of the benefit payment if any. The explanation of benefits statements are important because you can use the latest one to show your doctor and others when they want to know how much of the $50 deductible you have met.

When a Doctor Treats You

Medical insurance will help pay your doctor bills for all covered services you receive in the United States. Payment can be made no matter where a doctor treats you—in a hospital, his office, an extended care facility, your home, or at a group practice or other clinic.

You select your own doctor. He does not have to "sign up" or make any other special arrangements with Medicare.

For covered services you receive from your doctor, the medical insurance payment can be made either to you or to your doctor. See page 22 for the two ways payment can be made.

The following list shows the kinds of doctors' services that medical insurance will help pay for and some of the services it cannot pay for.

Part B Helps Pay For:

- Medical and surgical services by a doctor of medicine or osteopathy.
- Certain medical and surgical services by a doctor of dental medicine or a doctor of dental surgery.
- Services by podiatrists which they are legally authorized to perform by the State in which they practice. '67
- Other services which are ordinarily furnished in the doctor's office and included in his bill such as:
  - Diagnostic tests and procedures
  - Medical supplies
  - Services of his office nurse
  - Drugs and biologicals which cannot be self-administered.

Part B Does NOT Pay For:

- Routine physical checkups.
- Routine foot care and treatment of flat feet, sprains, or partial dislocations. '67
- Eye refractions and examinations for prescribing or fitting eyeglasses. '67
- Hearing examinations for prescribing, fitting, or changing hearing aids.
- Immunizations (unless directly related to an injury or immediate risk of infection, such as an anti-tetanus shot given after an injury).
- Services of certain practitioners, for example:
  - Christian Science practitioners
  - Chiropractors
  - Naturopaths

Coverage of Dental Services

Medical insurance covers the services of dentists only when the services involve surgery of the jaw or related structures or setting of fractures of the jaw or facial bones.

Medical insurance does *not* pay for dental services such as the care, filling, removal, or replacement of teeth, or treatment of the gum areas nor for surgery or other services related to these kinds of dental care. However, if your doctor decides that your medical condition requires you to be a hospital bed patient while you receive dental care which is not covered, your hospital insurance can still help pay for the hospital services.

Laboratory and Radiology Services by Doctors When You Are a Bed Patient in a Hospital

'67 **Starting April 1, 1968, when you are a patient in a participating or otherwise qualified hospital and receive laboratory or X-ray and other radiology services, medical insurance will pay 100 percent of the reasonable charges for the doctors providing these services. (The *hospital* charges for these services are taken care of by your hospital insurance.)**

You may not receive any doctor bills for these services, because many hospitals and the doctors who perform these services have agreed that the hospital will collect all the payments due from Medicare. If you do receive doctor bills for these services, send them in as described on page 22 for full payment of the reasonable charge even though you have *not met* the $50 deductible.

SPECIAL RULE: Because the full reasonable charges are taken care of when you receive laboratory and radiology services as a bed patient, your expenses for such services on or after April 1, 1968, do not count toward the $50 deductible.

Ambulance Services

Medical insurance will help pay for ambulance transportation to a hospital only when (1) ambulance services are medically necessary to protect the health of the patient, (2) transportation by other means could endanger the patient's health, and (3) the patient is taken to the *nearest* hospital that is equipped to take care of him (or to one in the same locality). Under similar restrictions, medical insurance can help pay for ambulance services from one hospital to another, from a hospital to an extended care facility, or from a hospital or extended care facility to the patient's home, but only if his home is in the same locality as the hospital or extended care facility.

Outpatient Hospital Benefits

When people go to the hospital for diagnosis or treatment and are not admitted as bed patients, the services they receive are called *outpatient hospital services.*

'67 Before April 1, 1968, certain limited outpatient diagnostic services were covered by hospital insurance. Starting April 1, 1968, covered outpatient services whether for diagnosis or treatment are paid by medical insurance.

After the $50 deductible has been met, Medicare takes care of 80 percent of the reasonable charges for all covered outpatient hospital services you receive.

Usually the hospital will apply for the Medicare payment and will charge you for any part of the $50 deductible you have not met plus 20 percent of the remaining reasonable charges for the outpatient services.

If the charge is $50 or less and the hospital cannot determine how much of the $50 deductible you have met, then the hospital may ask you to pay the entire bill. If you pay the bill, any Medicare payments that are due will be paid directly to you. Except in unusual circumstances, the hospital will prepare the Medicare claim for you. If you ever need help with your claim, get in touch with your social security office.

When you pay an outpatient bill of $50 or less, here is what happens:

- *If you have already met the $50 deductible*—Medicare will pay you 80 percent of the amount you paid the hospital.
- *If you have not met the $50 deductible*—Medicare will credit the amount you paid toward your $50 deductible. If that amount plus any part of the deductible you have previously met for the year adds up to more than $50, medical insurance will pay you 80 percent of the amount above the $50 deductible.

EXAMPLE: During the year, Mrs. J had bills of $45 for covered services *before* she received treatment in the hospital outpatient department. The hospital charged her $10 and she paid the bill at their request. When her claim is received, $5 of the outpatient bill is used to make up her $50 deductible and Mrs. J receives 80 percent of the remaining $5, which would be $4.

IMPORTANT:

When you go to a hospital for outpatient services, be sure to show the people there your most recent explanation of benefits statement (see page 15). From this form, they can tell how much of the $50 deductible you have met and how much of the deductible, if any, they may charge you.

Outpatient Hospital Benefits (continued)

The following list describes the kinds of outpatient hospital services that medical insurance will help pay for and some of the services that it cannot pay for:

Part B Helps Pay For:	Laboratory services such as blood tests and electrocardiograms.
	X-ray and other radiology services.
	Emergency room services.
	Medical supplies such as splints and casts.
Part B Does NOT Pay For:	Tests given as part of a routine checkup.
	Eye refractions and examinations for fitting or prescribing eyeglasses.
	Immunizations (unless directly related to an injury or immediate risk of infection, such as an anti-tetanus shot given after an injury).
	Hearing examinations for prescribing, fitting, or changing hearing aids.

Outpatient Physical Therapy Services

Physical therapy services are covered by medical insurance when they are furnished under the direct supervision of a doctor or when they are furnished as part of covered home health services.

'67 Also, beginning July 1, 1968, physical therapy services are covered when they are furnished by a qualified hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency, and they are furnished under a plan established and periodically reviewed by a doctor.

Emergency Outpatient Care from Certain Non-participating Hospitals Can also be Covered

'67 If you receive emergency outpatient care from a non-participating hospital which meets certain conditions, the Medicare payment will ordinarily be made to the hospital. In this case, they will bill you for any part of the $50 deductible you have not met plus 20 percent of the remaining reasonable charges.

The hospital may, however, elect to bill you. If the hospital bills you, just send in the itemized bill as described under the Payment-to-You method on page 22. In this case, medical insurance will pay *you* 80 percent of the reasonable charges (after the $50 deductible has been met). If you want help in making your claim, get in touch with your social security office.

Home Health Benefits

These are the same types of home health benefits provided under hospital insurance—services in your home by nurses, physical therapists, and other health workers from a participating home health agency—but *you do not have to be hospitalized first to get home health benefits under medical insurance.*

Your medical insurance will help pay for up to 100 home health visits each calendar year if all of the following are true:

1. You are confined to your home;
2. A doctor determines you need home health care;
3. A doctor sets up and periodically reviews the plan for home health care.

For an explanation of how home health "visits" are counted, see Question 9 on page 13.

Home health visits under hospital insurance and under medical insurance are separate benefits, and the visits you receive under one do not affect the number available under the other.

However, if you are entitled to home health visits under both parts of the program at the same time, any home health visits available under hospital insurance will be counted first.

The home health agency always makes the claim for the benefit payment, so you do not submit a *Request for Medicare Payment* form when you receive home health services. Since medical insurance takes care of 80 percent of the reasonable charges, the agency will bill you for any part of the $50 deductible you have not met plus 20 percent of the remaining reasonable charges.

The following list describes the kinds of home health services that medical insurance will help pay for and some of the services that it cannot pay for.

Part B Helps Pay For:	Part-time nursing care.
	Physical, occupational, or speech therapy.
	Part-time services of home health aides.
	Medical social services.
	Medical supplies furnished by the agency.
	Use of medical appliances.
Part B Does NOT Pay For:	Full-time nursing care.
	Drugs and biologicals.
	Personal comfort or convenience items.
	Custodial care.
	Meals delivered to your home.

Other Medical Services and Supplies

This benefit helps you pay for a number of different medical services and supplies which may be necessary in the treatment of an illness or injury. They may be furnished by your doctor as part of his treatment, or by the outpatient department of a hospital, or a medical clinic in connection with your treatment.

When a participating hospital, extended care facility, or home health agency provides covered services and supplies, it will make the claim for the Medicare payment and will bill you for any of the $50 deductible you have not met and 20 percent of the remaining reasonable charges. Otherwise you or the supplier of services will make the claim, as described on page 22.

The following list shows the kinds of medical services and supplies that medical insurance can help pay for when they are medically necessary and ordered by your doctor and some that it cannot pay for.

Part B Helps Pay For:

- Diagnostic tests such as X-rays and laboratory tests.*
- Radiation therapy.*
- Portable diagnostic X-ray services furnished in your home under a doctor's supervision. '67
- Surgical dressings, splints, casts, and similar devices.*
- Rental or purchase of durable medical equipment prescribed by a doctor to be used in your home: for example, a wheelchair, hospital bed, or oxygen equipment. '67
- Devices (other than dental) to replace all or part of an internal body organ. This includes corrective lenses after a cataract operation.
- Certain ambulance services.

Part B Does NOT Pay For:

- Prescription drugs and drugs you can administer yourself. For example, insulin injections for a diabetic condition.
- Hearing aids.
- Eyeglasses.
- False teeth.
- Orthopedic shoes or other supportive devices for the feet—except when shoes are a part of leg braces.

'67 * If you are a patient in a hospital or extended care facility and, for some reason, your hospital insurance cannot pay for these services (for example, because you have used up your benefit days), medical insurance can help pay for them.

How to Claim Medical Insurance Benefits

1. PAYMENT TO YOUR DOCTOR OR SUPPLIER

If you and your doctor (or supplier) agree that he will apply for the medical insurance payment, it will be made directly to him. This is called "assignment" of the benefit.

A. Complete and sign Part I of the *Request for Medicare Payment* (Form SSA-1490). (A copy of this form is on page 25.) Often your doctor's office or the supplier will complete Part I as a convenience to you.

B. Your doctor or supplier completes Part II of the form.

C. Your doctor or supplier sends in the *Request for Medicare Payment* form.

When your doctor or supplier accepts assignment, he agrees that his total charge will not exceed the reasonable charge (see page 15). This means that you are responsible only for any of the $50 deductible not yet met, plus 20 percent of the balance of the "reasonable charges."

---

2. PAYMENT TO YOU

If either you or the doctor (or supplier) do not want to use the assignment method, the medical insurance payment can be made directly to you. ***You can now make a claim with an itemized bill whether or not it has been paid.*** **(This is one of the important 1967 changes in the law.)**

A. Complete and sign Part I of the *Request for Medicare Payment* form. Often your doctor's office or the supplier will complete Part I as a convenience to you.

B. Your doctor or supplier will either complete Part II or give you an itemized bill. An itemized bill shows the date, place, and description of each service, and the charge for each service. (Be sure your name and claim number are on each bill exactly as they are shown on your health insurance card.)

C. You send in the *Request for Medicare Payment,* with either Part II completed or with itemized bills, to the organization which handles claims for the *area where you received services.* These organizations are listed on pages 27 to 29.

NOTE:

You may send in a number of bills from the *same* doctor or supplier (or from different doctors or suppliers) with a single *Request for Medicare Payment* form.

Also, whichever method you use, if you have health insurance in addition to Medicare or you are covered under a State program which pays all or part of your health care, be sure to fill in Item 5 of your *Request for Medicare Payment* form. (See page 25.)

When to Send in Your First Claim Each Year

Medical insurance does not pay any of the first $50 of covered medical expenses in each year. Generally, you should not send in your small bills until they have gone over $50. Then send them *all* in with your first claim for payment. In this way, you will save yourself extra work and, because it is less expensive to process just one claim rather than separate claims for each small bill, this will help reduce the costs of the program (you pay half of the program costs through your monthly premiums).

In some cases, of course, you may want to send them in before you have a total of $50. For example, you may already have $40 in small medical bills when you receive services from a doctor for $25 and he agrees to take your assignment. In that case, you would send in your $40 in prior bills, so that when the assignment is processed for payment the record will show that you have met $40 of the $50 deductible.

Your social security office will always be glad to answer your questions about when to send in your first claim.

If You Belong to a Group Practice Prepayment Plan

Group practice prepayment plans represent a special way of making health services available to their members. Generally, each member pays regular premiums to the plan in advance and this entitles him to receive any of the health services the plan provides, whenever he needs them, without paying a separate fee for each health service he receives. Congress took steps to assure that these plans could participate in the Medicare program while continuing their established method of operation.

Almost all group practice prepayment plans have made special arrangements with the Social Security Administration to receive direct payment for covered services they furnish their members who are medical insurance beneficiaries.

If you are a member of a plan which has made these special arrangements:

You **DO NOT** need to make a claim for any covered services which are provided through your group practice prepayment plan.

You **DO** need to make a claim for any covered services you receive which are not provided by your plan. In making your claim, you use one of the two methods described on page 22.

In addition, each plan has developed special methods to credit your membership premium payments or your use of plan services to the $50 deductible. Your plan will, of course, advise you of its method.

If you need more information, get in touch with your group practice prepayment plan.

When the Carry-Over Deductible Helps You

To help the beneficiary who might otherwise need to meet the $50 deductible twice in a short period, there is a special "carry-over" rule. This rule is that covered expenses you have in October, November, or December of any year can count as a credit toward the deductible not only for that year, but **also** for the following year.

- *If your expenses for covered services are $50 or less for a year,* then any expenses for covered services that you have in October, November, or December of that year can count toward the $50 deductible for the next year.

  For example, in the year 1968 your expenses for covered services were $45. Of this, $30 was for services received in the last 3 months of the year. You can count the $30 as part of the $50 deductible for the next year. This means that when your covered medical expenses for the next year go *over* $20, you will have met the $50 deductible for that year. ***So be sure to send these carry-over bills in with your first claim the next year.***

- *If your expenses for covered services do not go over $50 until the last 3 months of a year,* then any expenses in the last 3 months which counted toward the $50 deductible for that year can be counted *again* toward the $50 deductible for the *next* year.

  For example, your expenses were $20 for January through September and $70 for October through December 1967 (making a total of $90). You can count $30 of the October–December expenses toward the $50 deductible for 1967—and you can count the $30 *again* toward the $50 deductible for 1968.

  Of course, since you have met the $50 deductible for 1967, medical insurance pays 80 percent (or $32) of your $40 of expenses *above* the deductible.

Time Limits for Payment of Claims

'67 Under the law, there are some time limits for making payment on claims you send in. These limits are as follows:

WHEN SERVICES WERE RECEIVED	WHEN CLAIMS MUST BE FILED
October 1, 1966–September 30, 1967	By December 31, 1968
October 1, 1967–September 30, 1968	By December 31, 1969
October 1, 1968–September 30, 1969	By December 31, 1970

NOTE: For services received between July 1, 1966, and September 30, 1966, the time limit for sending in claims ended on April 1, 1968.

The New Request for Payment Form

The next page shows the new *Request for Medicare Payment* form. The new form includes the 1967 change in Medicare under which you can make a claim for payment whether or not your bill has been paid.

Of course, if you still have one of the older forms, you can use it for your next claim. If you do not have a claim form, you can use the form on the next page. Just cut it out along the line.

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

(See Instructions on Back—Type or Print Information)

Form Approved
Budget Bureau No.
72-R0730

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

A

Copy from your HEALTH INSURANCE CARD (See example on back)

1 Name of patient

2 Health insurance claim number

☐ Male ☐ Female

3 Patient's street address

City, State, ZIP code

Telephone Number

4 Describe the illness or injury for which you received treatment (*Always fill in this item if your doctor does not complete Part II below*)

Was your illness or injury connected with your employment?

☐ Yes ☐ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.

Insuring organization or State agency name and address

Policy or Medical Assistance Number

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of patient (*See instructions on reverse where patient is unable to sign*)

Date signed

SIGN HERE

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (*If related to unusual circumstances explain in 7C*)	Leave Blank
				$	

8 Name and address of physician or supplier (*Number and street, city, State, ZIP code*)

Telephone No.

Physician or supplier code

9 Total charges $

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill

☐ I accept assignment ☐ I do not accept assignment

13 Show name and address of facility where services were performed (*If other than home or office visits*)

14 Signature of physician or supplier (*A physician's signature certifies that physician's services were personally rendered by him or under his personal direction*)

☐ MD ☐ DO ☐ DDS

Other degree _____

Date signed

*O—Doctor's Office
IL—Independent Laboratory
H—Patient's Home (*If portable X-ray services, identify the supplier*)
IH—Inpatient Hospital
ECF—Extended Care Facility
OH—Outpatient Hospital
OL—Other Locations
NH—Nursing Home

FORM SSA-1490 (4-68)

Department of Health, Education, and Welfare
Social Security Administration

Cut along this line.

HOW TO FILL OUT YOUR MEDICARE FORM

There are two ways that Medicare can help pay your doctor bills

One way is for Medicare to pay your doctor.—If you and your doctor agree, Medicare will pay him directly. This is the assignment method. You do not submit any claim; the doctor does. All you do is fill out Part I of this form and leave it with your doctor. Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge; you are responsible for the deductible and coinsurance. Please read Your Medicare Handbook to help you understand about the deductible and coinsurance. (Because Medicare has special payment arrangements with group practice prepayment plans, these plans handle all claims for covered services they furnish to their members.)

The other way is for Medicare to pay you.—Medicare can also pay you directly—before or after you have paid your doctor. If you submit the claim yourself, fill out Part I and ask your doctor to fill out Part II. If you have an itemized bill from him, you may submit it rather than have him complete Part II. (This form, with Part I completed by you, may be used to send in several itemized bills from different doctors and suppliers.) Bills should show who furnished the services, the patient's name and number, dates of services, where the services were furnished, a description of the services, and charges for each separate service. It is helpful if the diagnosis is also shown. Then mail itemized bills and this form to the address shown in the upper left-hand corner, Block A. If no address is shown there, use the address listed in Your Medicare Handbook—or get advice from your nearest social security district office.

SOME THINGS TO NOTE IN FILLING OUT PART I (Your doctor will fill out Part II).

1 & 2 Copy the name and number and indicate your sex exactly as shown on your health insurance card. Include the letters at the end of the number.

3 Enter your mailing address and telephone number, if any.

4 Describe your illness or injury. Be sure to check one of the two boxes.

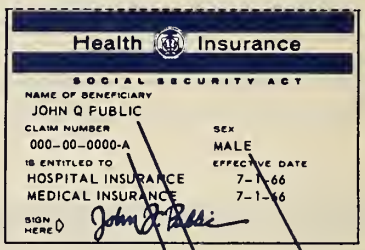
5 If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.

6 Be sure to sign your name. If you cannot write your name, sign by mark (X), and have a witness sign his name and enter his address on this line.

If the claim is filed for the patient by another person he should enter the patient's name and write "By", sign his own name and address in this space, show his relationship to the patient, and why the patient cannot sign. (If the patient has died the survivor should contact the nearest social security office for information on what to do.)

IMPORTANT NOTE.—This form may also be used by a supplier, or by you to claim reimbursement for charges by a supplier for services such as the use of an ambulance or medical appliances.

If the physician or supplier does not want Part II information released to the organization named in item 5, he should write "No further release" in item 7C following the description of services.


Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JOHN Q PUBLIC

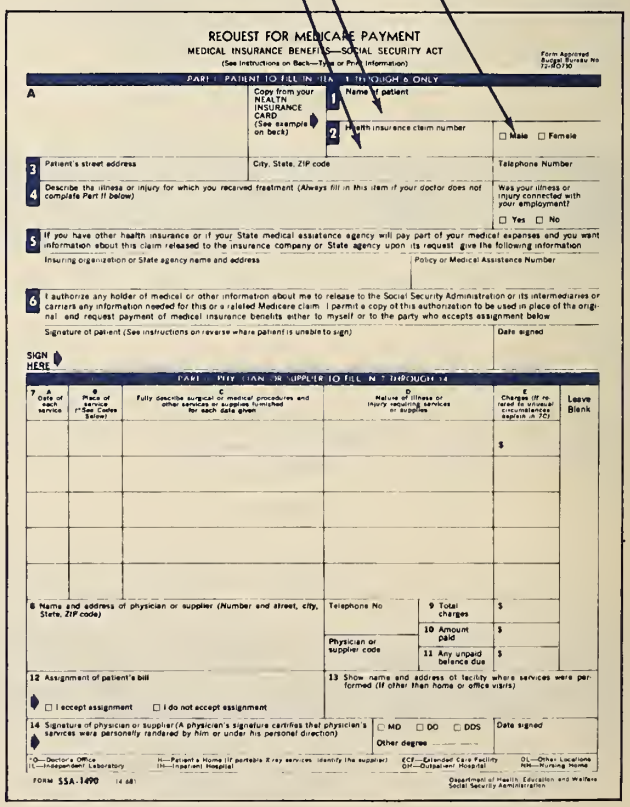
CLAIM NUMBER
000-00-0000-A

SEX
MALE

IS ENTITLED TO
HOSPITAL INSURANCE
MEDICAL INSURANCE

EFFECTIVE DATE
7-1-66
7-1-66

SIGN HERE ◊ John Q Public


REQUEST FOR MEDICARE PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(See instructions on Back—Type or Print Information)

Form Approved Budget Bureau No. 72-R570

PART I - PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

A

Copy from your HEALTH INSURANCE CARD (See example on back)

1 Name of patient

2 Health insurance claim number ☐ Male ☐ Female

3 Patient's street address | City, State, ZIP code | Telephone Number

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below) | Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request give the following information
Insuring organization or State agency name and address | Policy or Medical Assistance Number

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below
Signature of patient (See instructions on reverse where patient is unable to sign) | Date signed

SIGN HERE ◊

PART II - PHYSICIAN OR SUPPLIER TO FILL IN ITEMS 7 THROUGH 14

7 A Date of each service	B Place of service (See Codes Below)	C Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D Nature of illness or injury requiring services or supplies	E Charges (If referred to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code) | Telephone No | Physician or supplier code | 9 Total charges $ | 10 Amount paid $ | 11 Any unpaid balance due $

12 Assignment of patient's bill ◊ ☐ I accept assignment ☐ I do not accept assignment

13 Show name and address of facility where services were performed (If other than home or office visits)

14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction) ◊ ☐ MD ☐ DO ☐ DDS Other degree ____ | Date signed

O—Doctor's Office IL—Independent Laboratory H—Patient's Home (If portable X-ray services, identify the supplier) IH—Inpatient Hospital ECF—Extended Care Facility OH—Outpatient Hospital OL—Other Locations NH—Nursing Home

FORM SSA-1490 (4-68)

Department of Health, Education and Welfare
Social Security Administration

Where to Send Your Claim

The list below gives the names and addresses of the organizations selected by the Social Security Administration to handle medical insurance claims. These organizations are called carriers. In most cases, carriers handle claims for an entire State; a few handle claims for only part of a State. To find out where to send your medical insurance claim, look in the list for the State *where you received the services*. Under the name of the State (or, in some cases, under the list of counties within a State), you will find the name of the organization that will handle your medical insurance claim.

If you are not sure where your first claim should go, and happen to send your claim to the wrong office, don't worry. Your claim will be sent on to the right place. Be sure to include the word "Medicare" in the carrier's address on the envelope, and give *your* return address.

After you make a claim you will get a new claim form. It will usually show the carrier's name and address in the top left-hand corner. If you ever need to claim benefits, but you have no claim form, you can get one by phoning or writing your social security office (or you may use the one on page 25 of this handbook).

NOTE: If you are a railroad annuitant (even if you are also entitled to social security benefits), send your medical insurance claim to the Travelers Insurance Company office which is nearest to your home—no matter where you received services.

ALABAMA
Medicare
Blue Cross-Blue Shield of Alabama
930 South 20th Street
Birmingham, Alabama 35205

ALASKA
Medicare
Aetna Life Insurance Co.
522 SW. Fifth Street
Portland, Oregon 97204

ARIZONA
Medicare
Aetna Life Insurance Co.
3033 North Central Avenue
Phoenix, Arizona 85012

ARKANSAS
Medicare
Arkansas Blue Cross and Blue Shield
601 Gaines Street
Little Rock, Arkansas 72201

CALIFORNIA
Counties of:
Los Angeles and Orange
Medicare
Occidental Life Insurance Co.
of California
Box 54905
Los Angeles, California 90054

CALIFORNIA (continued)
Rest of State:
Medicare
California Physicians' Service
P.O. Box 7968, Rincon Annex
San Francisco, California 94119

COLORADO
Medicare
Colorado Medical Service, Inc.
244 University Boulevard
Denver, Colorado 80206

CONNECTICUT
Medicare
Connecticut General Life Insurance Co.
Meriden, Connecticut 06450

DELAWARE
Medicare
Blue Cross and Blue Shield
of Delaware
201 West 14th Street
Wilmington, Delaware 19899

DISTRICT OF COLUMBIA
Medicare
Medical Service of D.C.
1021 14th Street, NW.
Washington, D.C. 20005

FLORIDA
Medicare
Blue Shield of Florida, Inc.
P.O. Box 2525
Jacksonville, Florida 32201

GEORGIA
Medicare
John Hancock Mutual Life Insurance
Co.
P.O. Box 7340, Station C
Atlanta, Georgia 30309

HAWAII
Medicare
Aetna Life Insurance Co.
P.O. Box 3947
Honolulu, Hawaii 96812

IDAHO
Medicare
The Equitable Life Assurance Society
P.O. Box 8048
Boise, Idaho 83707

ILLINOIS
Counties of:
Cook
DuPage
Kane
Lake
Will

ILLINOIS (continued)

Medicare
Illinois Medical Service
425 North Michigan Avenue
Chicago, Illinois 60690

Rest of State:

Medicare
Continental Casualty Co.
P.O. Box 910
Chicago, Illinois 60690

INDIANA

Medicare
Mutual Medical Insurance, Inc.
110 North Illinois Street
Indianapolis, Indiana 46209

IOWA

Medicare
Iowa Medical Service
324 Liberty Building
Des Moines, Iowa 50308

KANSAS

Counties of:

Johnson	Wyandotte

Medicare
Surgical Care Inc.
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:

Medicare
Kansas Physicians' Service
1133 Topeka Boulevard
Topeka, Kansas 66601

KENTUCKY

Medicare
Metropolitan Life Insurance Co.
1218 Harrodsburg Road
Lexington, Kentucky 40504

LOUISIANA

Medicare
Pan-American Life Insurance Co.
P.O. Box 60450
New Orleans, Louisiana 70160

MAINE

Medicare
Union Mutual Life Insurance Co.
P.O. Box 4629
Portland, Maine 04112

MARYLAND

Counties of:

Montgomery	Prince Georges

Medicare
Medical Service of D.C.
1021 14th Street, N W.
Washington, D.C. 20005

Rest of State:

Medicare
Maryland Medical Service, Inc.
7800 York Road
Baltimore, Maryland 21203

MASSACHUSETTS

Medicare
Massachusetts Medical Service
133 Federal Street
Boston, Massachusetts 02106

MICHIGAN

Medicare
Michigan Medical Service
P.O. Box 2201
Detroit, Michigan 48231

MINNESOTA

Counties of:

Anoka	Ramsey
Dakota	Washington
Hennepin	

Medicare
The Travelers Insurance Co.
515 Marquette Avenue, South
Minneapolis, Minnesota 55402

Counties of:

Filmore	Olmstead
Goodhue	Wabasha
Houston	Winona

Medicare
The Travelers Insurance Co.
201 First Avenue, S W.
Rochester, Minnesota 55902

Rest of State:

Medicare
Blue Shield of Minnesota
2344 Nicollet Avenue
Minneapolis, Minnesota 55404

MISSISSIPPI

Medicare
The Travelers Insurance Co.
P.O. Box 22545
Jackson, Mississippi 39201

MISSOURI

Counties of:

Andrew	Henry
Atchison	Holt
Bates	Jackson
Benton	Johnson
Buchanan	Lafayette
Caldwell	Livingston
Carroll	Mercer
Cass	Nodaway
Clay	Pettis
Clinton	Platte
Daviess	Ray
DeKalb	St. Clair
Gentry	Saline
Grundy	Vernon
Harrison	Worth

Medicare
Surgical Care, Inc.
P.O. Box 169
Kansas City, Missouri 64141

MISSOURI (continued)

Rest of State:

Medicare
General American Life Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166

MONTANA

Medicare
Montana Physicians' Service
P.O. Box 1677
Helena, Montana 59601

NEBRASKA

Medicare
Mutual of Omaha Insurance Co.
P.O. Box 456, Downtown Station
Omaha, Nebraska 68101

NEVADA

Medicare
Aetna Life Insurance Co.
111 North Virginia Street
Reno, Nevada 89501

NEW HAMPSHIRE

Medicare
New Hampshire-Vermont Physician Service
One Pillsbury Street
Concord, New Hampshire 03301

NEW JERSEY

Medicare
The Prudential Insurance Co. of America
P.O. Box 6500
Millville, New Jersey 08332

NEW MEXICO

Medicare
The Equitable Life Assurance Society
P.O. Box 3070, Station D
Albuquerque, New Mexico 87110

NEW YORK

Counties of:

Bronx	Orange
Columbia	Putnam
Delaware	Richmond
Dutchess	Rockland
Greene	Suffolk
Kings	Sullivan
Nassau	Ulster
New York	Westchester

Medicare
United Medical Service, Inc.
Two Park Avenue
New York, New York 10016

County of:

Queens
Medicare
Group Health Insurance, Inc.
225 West 40th Street
New York, New York 10036

NEW YORK (continued)

Counties of:

Livingston	Seneca
Monroe	Wayne
Ontario	Yates

Medicare
Genesee Valley Medical Care, Inc.
41 Chestnut Street
Rochester, New York 14604

Counties of:

Allegany	Niagara
Cattaraugus	Orleans
Erie	Wyoming
Genesee	

Medicare
Blue Shield of Western New York, Inc.
298 Main Street
Buffalo, New York 14202

Counties of:

Albany	Montgomery
Broome	Oneida
Cayuga	Onondaga
Chautauqua	Oswego
Cheming	Otsego
Chenango	Rensselaer
Clinton	Saratoga
Cortland	Schenectady
Essex	Schoharie
Franklin	Schuyler
Fulton	Steuben
Hamilton	St. Lawrence
Herkimer	Tioga
Jefferson	Tompkins
Lewis	Warren
Madison	Washington

Medicare
Metropolitan Life Insurance Co.
P.O. Box 393
Utica, New York 13500

NORTH CAROLINA
Medicare
Pilot Life Insurance Co.
P.O. Box 22067
Greensboro, North Carolina 27420

NORTH DAKOTA
Medicare
North Dakota Physicians Service
301 Eighth Street, South
Fargo, North Dakota 58102

OHIO

Counties of:

Ashtabula	Lake
Cuyahoga	Loraine
Geauga	

Medicare
Medical Mutual of Cleveland, Inc.
2060 East Ninth Street
Cleveland, Ohio 44115

OHIO (continued)

Rest of State:
Medicare
Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216

OKLAHOMA
Medicare
Aetna Life Insurance Co.
7 South Harvey
Oklahoma City, Oklahoma 73102

OREGON
Medicare
Aetna Life Insurance Co.
522 SW. Fifth Street
Portland, Oregon 97204

PENNSYLVANIA
Medicare
Pennsylvania Blue Shield
Box 65
Camp Hill, Pennsylvania 17011

RHODE ISLAND
Medicare
Physicians' Service
444 Westminster Mall
Providence, Rhode Island 02901

SOUTH CAROLINA
Medicare
Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29206

SOUTH DAKOTA
Medicare
South Dakota Medical Service, Inc.
711 North Lake Avenue
Sioux Falls, South Dakota 57102

TENNESSEE
Medicare
The Equitable Life Assurance Society
P.O. Box 1465
Nashville, Tennessee 37202

TEXAS
Medicare
Group Medical and Surgical Service
P.O. Box 22147
Dallas, Texas 75222

UTAH
Medicare
Blue Shield of Utah
2455 Parley's Way, Box 270
Salt Lake City, Utah 84110

VERMONT
Medicare
New Hampshire-Vermont Physician Service
One Pillsbury Street
Concord, New Hampshire 03301

VIRGINIA

Counties of:

Arlington	Fairfax

VIRGINIA (continued)

City of:
Alexandria
Medicare
Medical Service of D.C.
1021 14th Street, NW.
Washington, D.C. 20005

Rest of State:
Medicare
The Travelers Insurance Co.
P.O. Box 10166
Richmond, Virginia 23230

WASHINGTON
Medicare
Washington Physicians' Service
Mail to your local Medical Service Bureau

WEST VIRGINIA
Medicare
Nationwide Mutual Insurance Co.
P.O. Box 3183
Charleston, West Virginia 25332

WISCONSIN

County of:
Milwaukee
Medicare
Surgical Care
P.O. Box 2049
Milwaukee, Wisconsin 53201

Rest of State:
Medicare
Wisconsin Physicians Service
Box 787
Madison, Wisconsin 53701

WYOMING
Medicare
The Equitable Life Assurance Society
P.O. Box 628
Cheyenne, Wyoming 82001

PUERTO RICO
Medicare
Seguros De Servicio De Salud De Puerto Rico
G.P.O. Box 3628
Hato Rey, Puerto Rico 00936

VIRGIN ISLANDS
Medicare
Mutual of Omaha Insurance Co.
P.O. Box 456, Downtown Station
Omaha, Nebraska 68101

AMERICAN SAMOA
Medicare
Social Security Health Insurance
Pago Pago
American Samoa 96920

GUAM
Medicare
Aetna Life Insurance Co.
P.O. Box 3947
Honolulu, Hawaii 96812

Questions and Answers about Medical Insurance

1. ***Where can I get more copies of the Request for Medicare Payment form?***

   Each time you send a claim to the carrier you will get back a new *Request for Medicare Payment* form to use for your next claim. Also, most doctors' offices have a supply of the forms. And you can always get extra copies from your social security office.

2. ***Is there a limit on what medical insurance will pay for doctors' services when the services are mainly for the treatment of mental illness?***

   Yes. When such services are furnished outside a hospital, the payment is limited to a maximum of $250 a year.

'67 3. ***Who makes the decision whether to rent or purchase durable medical equipment my doctor has prescribed for use in my home?***

   You do. When considering purchase, particularly of expensive equipment, you should keep in mind that the Medicare payments are made over a period of time, based on the reasonable rental rate for the equipment, and that these payments stop when your need for the equipment ends. So in deciding whether to purchase equipment, you may wish to talk to your doctor about how long you may need it. Your social security office can also help when you have any questions.

4. ***What happens if I want to assign the payment to a doctor, but he doesn't want to accept an assignment?***

   That is his right. He does not have to take an assignment of your benefits. If your doctor doesn't agree to take your assignment, the payment will be made directly to you if you submit an itemized bill, whether or not it has been paid.

5. ***If I assign the benefit to my doctor or supplier, does this mean all my future benefit claims must also be handled on an assignment basis?***

   No. The payment can be made directly to your doctor or supplier one time and the next time it can be made to you.

6. ***I understand that the medical insurance benefits are paid on a "reasonable charge" basis. Who decides what the reasonable charge is, and how does this affect payment?***

   The carrier determines "reasonable charge" for covered services. If there is an assignment, the doctor or supplier agrees that the reasonable charge will be his total charge and that he will charge *you* only for any of the $50 deductible not yet met and 20 percent of the balance of the "reasonable charge." If there is no assignment, medical insurance can pay *you* only 80 percent of the reasonable charge (after the $50 deductible is met), even if the bill exceeds the "reasonable charge." (See page 15.)

7. ***What can I do if I disagree with the amount paid on my claim?***

   Write to the carrier which handled the claim and tell why you disagree with the amount allowed. If you are still not satisfied with the reply, you can request a hearing from the carrier.

8. ***What if I cannot pay the amounts that medical insurance does not pay?***

   You may want to ask at your local public assistance office about help under a State program such as old age assistance or medical assistance for the aged (sometimes called "medicaid").

Some Health Services and Items That NEITHER Hospital Insurance Nor Medical Insurance Will Pay For

Under each kind of benefit described under hospital insurance, there is a list of items and services hospital insurance will not pay for. The medical insurance part of the book also has a list of items and services that medical insurance will not pay for. But there are some other items or services that are not covered under either part of Medicare. These are shown in the following list:

- Services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- Cosmetic surgery—*except when furnished in connection with prompt repair of accidental injury or for the improvement of the functioning of a malformed body member.*
- Services for which neither the patient nor another party on his behalf has a legal obligation to pay—*such as free chest X-ray.*
- Certain services payable under other Federal, State, or local government programs.
- Services furnished by immediate relatives or members of the patient's household.

The First 3 Pints of Blood

67 Medicare cannot pay for the first 3 pints of whole blood (or units of packed red blood cells) that you receive either under hospital or medical insurance.

- Hospital insurance cannot pay for the first 3 pints of blood you receive in a *benefit period*. Usually, you would receive blood under hospital insurance as a bed patient in a hospital.
- Medical insurance cannot pay for the first 3 pints of blood you receive in a *calendar year*. Usually, you would receive blood under medical insurance in a doctor's office, a clinic, or the outpatient or emergency department of a hospital.

These are *separate* rules and they operate independently of each other. For example, if you receive blood under both hospital insurance and medical insurance, Medicare could not pay for the first 3 pints of blood under *either* program.

HOW TO GET HELP TO REPLACE BLOOD

Some people are able to arrange for the replacement of these first 3 pints of blood—that way they don't have to pay for them. There are two ways this can be done. First, *you* may arrange for replacement from a friend or relative or you may be a member of a blood donor group that will replace these first 3 pints of blood for you. Second—and this is often overlooked—your children (or your son-in-law or daughter-in-law) may belong to a blood replacement plan that includes you as a beneficiary. In that case, you would be eligible for blood on the basis of *their* membership.

In almost all blood donor plans, blood replacement credit can be arranged anywhere in the United States. You might want to check with your children and children-in-law about this, so you'll have the information handy if you ever need it.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

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AND WELFARE

Where to Find the 1967 Changes

To find where the 1967 changes are described, look for this symbol on the page. (67)

For further information about Medicare or for help in any social security matter, call, write, or visit your social security office.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ● SOCIAL SECURITY ADMINISTRATION

☆ U.S. GOVERNMENT PRINTING OFFICE : 1968 O - 292-629

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 25 cents